

than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(B) The length of time in which the residents are being training at the rural nonhospital site(s) only.

(5) All urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitation, must also comply with all of the following conditions:

(i) An urban hospital may not include in its rural track FTE limitation or (assuming the urban hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.

(ii) The hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.

(iii) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural area, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive GME payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.

(6) If CMS finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, CMS will reopen the urban hospital's cost report within the 3-year reopening period as specified in § 405.1885 of this

chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

(1) For purposes of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.

(7) If an urban hospital had established a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent census data and implementation of the new labor market area definitions announced by OMB on June 6, 2003, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) for the rural track programs established prior to the adoption of such new labor market area definitions. In order to receive an adjustment to its FTE resident cap for a new rural track residency program, the urban hospital must establish a rural track program with hospitals that are designated rural based on the most recent geographical location designations adopted by CMS.

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**§ 413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.**

(a) The weighting factor for a foreign medical graduate is determined under the provisions of § 413.79 if the foreign medical graduate—

(1) Has passed FMGEMS; or

(2) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(b) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of § 413.79. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a

residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (a) of this section is .50 times the weight determined under the provisions of § 413.79.

(c) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(d) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of § 413.79 for the part of the cost reporting period beginning with the month the resident passes the test.

(e) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section.

(f) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section. On or after July 1, 1993, only the results of steps I and II of the United States Medical Licensing Examination will be accepted for purposes of making this determination.

[69 FR 49254, Aug. 11, 2004]

**§ 413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.**

(a) For purposes of determining direct GME payments, the following principles apply:

(1) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment.

(2) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

(b) *Application.* A hospital must continuously incur costs of direct GME of residents training in a particular pro-

gram at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of §§ 413.78, 413.79 (c) through (e), and 413.79(k). This rule also applies to providers that are paid for direct GME in accordance with § 405.2468 of this chapter, § 422.270 of this subchapter, and § 413.70.

(c)(1) *Effective date.* Subject to the provisions of paragraph (c)(2) of this section, payments made in accordance with determinations made under the provisions of paragraphs (a) and (b) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(2) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (a) and (b) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

[69 FR 49254, Aug. 11, 2004]

**§ 413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.**

(a) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b-1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(b) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which